MODULE 4: ADDRESSING THE UNIQUE NEEDS OF DIFFERENT POPULATIONS

> *The bottom line is that it was more than the attack on the World Trade Center. It happened here too, and not just to a military building, but to all the people who live and work in Northern Virginia. We need to grieve, to feel angry, and somehow, at the same time, to get on with our lives.*
>
> ——Virginia Governor Mark R. Warner

A mental health response to terrorism needs to reach out to the entire impacted community. In order to develop an all-inclusive outreach program, disaster mental health workers need to understand the demographic and cultural makeup of the community and its mental health implications. Certain cultural or ethnic groups may be affected uniquely by terrorist events. Some groups may experience backlash if the community associates them with the perpetrators of the terrorist event. Some groups, including immigrants, foreign students, and persons visiting from other countries may experience additional anxiety because of fear of deportation. A terrorist event may also lead to retraumatization among some refugees who experienced trauma in their native countries.

This module will help you assess and increase your cultural understanding of different groups and how to involve community gatekeepers in the disaster mental health response. It will show you how to identify the communities that are in need of services and resources, looking at factors such as level of exposure to an event and group-specific vulnerabilities that may be triggered. The module provides suggestions on how to customize mental health interventions to the unique needs of different groups based on culture/ethnicity, rural residence, age, disability, economic status, profession, and gender.

After completing this module, the learner will be able to:

- Assess and improve cultural understanding
- Work with community gatekeepers to enhance disaster mental health services and resources
- Increase access to and understanding of different populations

Looking Inward Before Looking Outward

Self-awareness about how well we understand groups of people who are different from ourselves is critical to our ability to serve them effectively. Before making contact with victims and survivors, it is recommended that disaster mental health workers take stock of their "cultural understanding" of the various groups that are affected by the disaster and that make up the communities in the area. How well understood and appreciated are these groups of people? How well can disaster mental health services address their beliefs and behaviors?

It is not uncommon for people, including disaster mental health workers, to:

- Inadvertently hold generalized beliefs about how some groups (such as age groups, genders, or racial/ethnic groups) react in crisis situations
- Feel more comfortable with groups that are more like themselves
- Soften professional boundaries in times of community crisis

Being aware of these tendencies can help the disaster mental health workers ensure that they provide the best possible services to communities in need.

The checklist in Table 4–1 will help evaluate behaviors that lead to effective interactions with these different populations:

Table 4–1. Checklist for Evaluating Cultural Competency[22]

Goal	How To Achieve It
Recognize the role of cultural beliefs and help-seeking behaviors.	_____ Recognize that the ability of the mental health worker to understand and respect survivors' cultural beliefs, language, and interpersonal style may help survivors to recover from traumatic experiences. _____ Talk with survivors about specific beliefs and customs that direct help-seeking behaviors and foster healing for them. _____ Understand the importance of issues such as space, time, and environmental control within different groups.
Understand natural support networks and healing practices.	_____ Recognize that, for groups centered around family and community, outreach that focuses only on the individual and that does not consider natural support networks might not be effective. _____ Find out who is important in survivors' lives by listening to how they describe their home, family, and community. _____ Be aware that different populations have different beliefs about what causes trauma and what leads to healing. _____ Help survivors to reestablish rituals and plan culturally appropriate commemorations.

[22] Adapted from Athey, J. (2003). Developing cultural competence in disaster mental health programs: Guiding principles and recommendations. (DHHS Publication No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Goal	How To Achieve It
Implement culturally competent outreach strategies.	_____ Recognize cultural differences related to accessing and communicating with different groups. Compose a community profile documenting these differences, which may include refugee status, income level, and literacy level. _____ Consult community gatekeepers to determine the best outreach strategies for specific populations. _____ Recruit mental health workers who reflect the demographic characteristics of the affected community. If workers from the community are not available, recruit others with similar backgrounds and language skills.
Ensure that outreach services are accessible, appropriate, and equitable.	_____ Recognize that different groups might be hesitant to use your services because of distrust of government and mental health stigmas. _____ Address concerns related to groups (e.g., refugees) who have suffered political oppression and are wary of government assistance. _____ Work to eliminate barriers to service such as language differences, mental health stigmas, and physical disabilities. _____ Establish a plan for preparing culturally appropriate materials and services, such as brochures in languages other than English and information sessions for people who are deaf or hard of hearing. _____Use existing community resources (e.g., faith communities, local radio programs) to disseminate messages.
Assess and evaluate the program's level of cultural competence.	_____ Continually evaluate the program to determine how to improve the planning and delivery of culturally competent services. _____ Involve community gatekeepers in the program evaluation.

Teaming To Increase Access and Provide Better Services

One important strategy to effectively reach affected communities is to partner with organizations that represent specific communities in need of disaster mental health services. These organizations can provide both access into and a better understanding of their communities.

I was very proud of what we did in our community to respond to 9/11. The decision was made early on that, when we did our outreach crisis counseling program in our community, we would contract with organizations that were ethnically based or ethnically connected, because we knew that a large majority of the people who would be impacted by 9/11 would be members of minority groups. So we contracted with ethnic organizations to provide outreach counselors and their supervisors. We then provided training to them. The training was provided intensively in the beginning and then on an ongoing basis over the life of our project. So, by using organizations that had an affiliation with a particular ethnic group, the project had improved credibility in the target communities and, thus, penetrated the communities much more quickly than if we had had to establish our credibility.

Donna M. Foster, M.S.W.
Project Director, Fairfax County
Community Resilience Project

Community gatekeepers can also help gain survivors' trust and acceptance. The Patriot Act has increased fears that people's immigration status may be reviewed and result in their deportation. Therefore, they may be less likely to seek help. An endorsement of the disaster mental health worker by a trusted member in their community, however, may help provide credibility and the access necessary to be accepted and better able to provide needed services.

Once the gatekeepers are identified, it is important to explain how disaster mental health workers can help them during difficult times. It is also important to demonstrate respect for how their organizations operate and explain how disaster mental health services can help their community.

Community-based organizations include:

- Civic and volunteer groups
- Neighborhood associations and watch-groups
- Recreational and social clubs
- Religious organizations
- Professional or business groups
- Interfaith groups
- Mutual aid societies
- Nonprofit advocacy organizations
- Health care and social service networks

It is also helpful to identify mental health professionals from these groups and to recruit people interested in becoming paraprofessionals to assist with outreach and intervention efforts. They can be powerful peer counselors and bring major benefits to your program by gaining access to different populations, providing appropriate language skills, and lending credibility and trust.

Other community gatekeepers may be found in religious organizations, schools, and neighborhoods and include religious leaders, teachers, coaches, local business owners, librarians, historians, and long-time residents.

Community cohesion includes learning about each other—immigrants knowing more about area programs and services, and natural-born citizens learning about the cultures of immigrants. We worked to promote community cohesion by holding community forums and by reaching out to individuals and groups to help struggling immigrants access the services that were available to them. The immigrants on our outreach team acted as goodwill ambassadors to those they came into contact with, sharing their culture and experience.

Deborah Warren, L.C.S.W., D.C.S.W.
Project Director, Alexandria
Community Resilience Project

Community gatekeepers can help:

- Assess needs and identify communication and access issues
- Identify needs in the community
- Develop strategies for responding to specific groups
- Organize support groups and meetings
- Translate materials
- Distribute materials
- Translate for survivors who do not speak English or who use sign language

Community gatekeepers also can train mental health disaster workers and give suggestions on how group members seek help. Ongoing training sessions might focus on using strengths, such as strong family ties and previous recovery from crisis, to build resilience. Other important training topics gatekeepers may assist with are:

- Cultural competence
- Linguistics
- Literacy and education levels
- Communication and access issues
- Experience with terrorism or other disasters
- Family and community values

- Support systems
- Experience with public assistance agencies or other "outside" help
- Mental health stigmas

Identifying Communities in Need of Services and Resources

Assessing the potential mental health needs of different groups following a terrorist event includes a review of the three elements described below. High levels of any of these indicate a need for monitoring and possible intervention.

- **Nature and severity of the event.** This can be assessed several ways. One obvious way is by looking at the number of casualties and the amount of property damage that result from the event. However, the level of terror and fear spread among communities and individuals may not necessarily coincide with casualties or property damage. The sniper attacks that took place in the Washington, DC, metropolitan area and Virginia in the Fall of 2002 claimed a much smaller number of lives than the terrorist attacks of September 11, 2001; however, some people in the region felt that terror that stemmed from the attacks affected more of the general population because the sniper was "on the loose" for many weeks. For more information on assessing nature and severity, see Module 2.

- **Level of exposure/proximity to the event.** Terrorism affects the entire community, but it most severely affects those who experience the event directly or those who have previously been traumatized by a terrorist-related event. For more information on the Population Exposure Model and the "ripple effect," see Module 2.

- **Group-specific vulnerabilities that could be aggravated by the event.** These are further explained in the following sections.

A comprehensive needs assessment considers language and communication barriers and access issues of different populations. Persons who do not speak English, are deaf or hard of hearing, or are illiterate, for example, are at a significant disadvantage if services are not easily accessible to them. Someone from a cultural group that considers physical contact with strangers to be inappropriate will have a negative reaction if a disaster mental health worker touches their arm as a sympathetic gesture. Someone who only seeks advice from his/her religious leader might not listen to "outside" help. Understanding these potential barriers will lead to better intervention/service provision decision-making.

It is also important to know about individual vulnerabilities that affect how someone reacts to terrorism. The National Center for Post-Traumatic Stress Disorder advises, "Some individuals have a higher than typical risk for severe stress symptoms and lasting PTSD, including those with a history of:

- Exposure to other traumas (such as severe accidents, abuse, assault, combat, rescue work)
- Chronic medical illness or psychological disorders

- Chronic poverty, homelessness, unemployment, or discrimination
- Recent or subsequent major life stressors or emotional strain (such as single parenting)."[23]

Community gatekeepers can help put together a community profile to determine potential vulnerabilities and other factors that might influence the mental health of their communities. They can work with community gatekeepers to research and collect information to gain insight into a particular community with regard to factors such as:

The challenges we saw had to do with miscommunication, not understanding different cultures—the way different people perceive things, their different religious points of view, where they had come from. Many people think that their way of thinking is the only way of thinking, but there are other views and values that need to be recognized and understood.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

- Race/ethnicity
- Refugee and immigrant status
- Age
- Gender
- Religion
- Attitudes (including mental health stigmas)
- Lifestyles and customs
- Interests
- Values
- Beliefs
- Physical disability status
- Mental/emotional disability status
- Family frameworks (e.g., single-parent, blended-family, or multiple-family households)
- Income levels
- Professions and unemployment rate
- Languages and dialects
- Education and literacy levels

[23] National Center for Post-Traumatic Stress Disorder. Helping Survivors in the Wake of a Disaster—A National Center for PTSD Factsheet. Retrieved at http://www.ncptsd.org/facts/disasters/fs_helping_survivors.html.

Demographic information is also available from the U.S. Census Bureau and local government agencies.

Providing Services to Different Populations

The face of the United States is constantly changing. Suburban sprawl, migration, and changing employment opportunities have created a more transient population and shifting demographics. To anticipate how these changes affect disaster mental health services, it is useful to learn about the people within the affected community.

You have to listen to the concerns of those communities, and you need to be respectful. It is important to listen to what they're saying, what their needs are, and how they are distinguished from the "majority" society. Of course, the project cannot ignore the majority society. But, in order to reach these communities…you need to listen to them so that they feel that their needs are being fairly addressed by the services that you are delivering.

Donna M. Foster, M.S.W.
Project Director, Fairfax County
Community Resilience Project

This section:

- Describes the populations that emerged as having unique needs during the Northern Virginia experience with terrorism
- Identifies factors that may affect mental health service provisions
- Provides recommendations for providing mental health services

If another terrorist event takes place, other populations in addition to those described here may be uniquely affected and will be targeted for services.

Culture/Ethnicity

Among many other things, terrorist events can heighten a community's sense of fear, suspicion, and vigilance. Some cultural/ethnic groups may experience backlash if the community associates them with the perpetrators of the terrorist event. Post-9/11, many Muslim Americans and Korean Americans in Northern Virginia were the victims of backlash. Backlash can happen anywhere, anytime—as people work, go to school, shop, or try to cross the street—as the examples below from Fairfax County illustrate.

- Several people, especially women wearing the hijab (scarf for head cover), reported being almost hit by a car while walking.
- Two mosques were vandalized in 6 months—one was painted with swastikas and hate messages; the other had a school bus burned while parked on the mosque property.
- Afghani taxi drivers reported being regularly insulted by their customers.
- One Muslim woman, working in a retail establishment, was accosted by a customer and told "Go home!"

- One African-American Muslim child was hit at school by a classmate who, when questioned by his teacher as to why he hit the Muslim child, told the teacher he/she hit the Muslim child because he was "Afghani."

- A male, Muslim apartment owner, who forgot his key, was not let in by another resident because "he might be a terrorist"; the female resident insisted on calling the police.

- The tensions between North Korean and the U.S. over nuclear capability have created a new type of anxiety similar to that which immigrants from Muslim countries have experienced. Vans that belonged to the Korean Crisis Counseling teams were vandalized twice while parked at a church. The vans belonging to the church were not touched.

Post-event law enforcement activities also can add to the fear that certain cultural/ethnic groups experience. See the examples below.

- In March 2002, armed federal agents who were looking for terrorist ties in Northern Virginia raided about 20 homes and businesses owned by Muslims. Although no one was indicted, the cases generated a constant fear of more such raids.

- The Immigration and Naturalization Service (INS) started to register all Muslim non-U.S. citizen males as a part of the terrorist tracking. Some who went to register were arrested on minor visa violations and deported.

- FBI and other federal agents visited mosques and questioned people about their friends and other members of the congregation.

- Hundreds of Iraqis and Muslims were detained for "questioning" for long periods after the war in Iraq started, creating fear in the Muslim community.

While providing services to members of cultural/ethnic groups, it is important for disaster mental health workers to understand that members of the same group may hold different political, cultural, and religious views from each other. Therefore, it is critical that disaster mental health workers not align themselves with—or distinguish themselves from—a particular view or tradition. In other words, they need to stay neutral.

The Middle Eastern Muslim population is within itself a very diverse group of people, and they don't necessarily collaborate with each other or with the government very often. And so when we set up that contract, it was a real challenge to get four different mosques to develop programs, to identify people with the right kinds of skills, to represent their ethnicities and their different factions within those ethnicities on the teams. This was important so that the entire Middle Eastern Muslim community felt represented and was approached in terms of the services that they needed.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

Recent Immigrants

Recent immigration to the United States is another major factor that surfaced throughout Northern Virginia's response efforts. Uprooting one's life and moving to another country is stressful. Not only do immigrants need to adapt to a new language, but they are also assimilating to a new culture, which leaves them more vulnerable during a crisis. This vulnerability may be intensified by the following:

- Leaving behind social support systems (e.g., family, friends) and trying to establish new ones
- Securing employment and financial stability
- Changing family member roles (e.g., adults could develop an unfamiliar dependency on children who learn English quickly)
- Adapting to a new culture and environment

Refugee Community

The hardships of refugee communities lead to the potential for retraumatization as well. In fleeing their native countries because of social or political disorder, many refugees have suffered loss of loved ones and possessions. A terrorist event could remind them of past pain and lead to retraumatization—or a show of resilience that comes from already having experience with difficult situations. It is important to acknowledge the trauma in their history and validate the insight and strength of refugees. Some refugees feel betrayed by their native country and are cautious of building friendships in their new homelands, except with a select few. This distrust—especially in refugees who suffered from political oppression—extends to police officers, the military, social service workers, and government employees, making some refugees hesitant to seek out and accept help.

Below are some points to consider when working with refugees.

- Respect their views about assistance agencies and staff members.
- Team with appropriate community gatekeepers.
- Approach refugees lightly, displaying courtesy and cultural competence.
- Take time to earn the confidence of refugees.

It is very important to respect and address different linguistic needs. Materials should be translated into the languages that are spoken in the community. Virginia is home to people of many native countries, religions, and ethnicities. For example, in Arlington County alone, more than 60 different languages are spoken by students enrolled in the Limited English Proficiency

program.[24] More than 100 languages are spoken at one school in Fairfax County. Services should be available in the most common languages spoken by disaster survivors, including American Sign Language, and interpreters should be identified for as many other languages as possible. Staff should have strong ties to the communities they will be serving. Sometimes there may be a need to use an outside interpreter. The following box provides some guidelines for working with interpreters.

Guidelines for Using Interpreters[25]

- Determine survivors' language and dialect needs first.
- Hire certified interpreters who share a community's racial/ethnic background. If this is not possible, give interpreters training in cultural competence.*
- Monitor signs of the interpreter's potential biases and comfort level with topics. Allow time for the interpreter and survivor to establish rapport and trust through informal conversation.
- Use a consistent style of interpretation that is easy to follow. For example, the survivor speaks and the interpreter translates for the mental health worker, or the mental health worker speaks and the interpreter translates for the survivor.
- Allow at least twice as much time for interactions to take place.
- Avoid using a survivor's family members—particularly, children—and friends as interpreters. Survivors could feel uncomfortable or ashamed to discuss their concerns through them.

** To the extent possible, the disaster mental health worker should prepare the interpreter on providing services to a person of that particular community.*

Other issues that may vary based on cultural/ethnic differences are feelings about time and destiny. Some groups and individuals may consider being on time extremely important, while others may be more flexible with schedules. Be aware of such attitudes, and respect these differences by not imposing rigid timetables or by being late to appointments.

People who believe their recovery is in the hands of an external force—luck, fate, or divine intervention—might not understand initially how a disaster mental health worker can help them. On the other hand, those who believe they have the power to heal themselves may be more receptive to crisis counseling services.

Children

Children process information, and experience and express emotions differently than adults. Disasters, violence victimization, and sudden deaths of loved ones are experienced within the context of a child's psychological development, life and family situation, and critical caretaking relationships.[26] Terrifying events can cause overwhelming and unfamiliar physical reactions and

[24] Federation for American Immigration Reform. Virginia: Social policy issues. Accessed 2003 at the Federation for American Immigration Reform Web site: http://www.fairus.org/html/042vasoc.htm.
[25] Adapted from Athey, J. (2003). Developing cultural competence in disaster mental health programs: Guiding principles and recommendations. (DHHS Publication No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[26] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

emotions that can be traumatizing to children (see Module 3 for lists of normal reactions to terrorist events in children).

Children have a difficult time deciding what is fact and what is fantasy, which leads to fear and confusion. In trying to make sense of what has happened, children often blame themselves for causing or worsening the incident, which can lead to feelings of guilt and shame.

Very young children depend on a stable environment and reliable people to take care of them. As children become older, they may try to understand why the event happened and what will happen next. Family, significant adults, pets, playmates, school, and neighborhoods are important features in a child's world. When a terrorist event takes place in a community, many of the significant features may be disrupted or destroyed.

Eventually, over time and with a lot of perseverance, we developed very good relationships with some key people within the community. We developed a very good network with libraries, for example, where they were actually referring people to us. People were going to the libraries saying that their children were really upset about 9/11 or the sniper, and they wanted books. Since the libraries didn't have any relevant books, they would refer them to us. Over time, we worked with the libraries to develop their library system so they did have the books, magazines, and handouts available so that they could help people in an ongoing effort.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

The sniper attacks that occurred in Virginia, Maryland, and Washington, DC, greatly affected school staff and school children. Children were locked down in schools (i.e., not permitted to leave the school building during school hours) for weeks. Police officers were stationed at the schools and, in some communities, they escorted buses. Homecomings and sports events were cancelled. Opportunities were lost that can never be regained.

Consider the following when assessing a child's potential for trauma and planning a mental health response:

- Direct threat to life and physical safety
- Degree of cruelty by violence and weapons
- Seeing graphic acts of death and injury
- Hearing cries for help
- The event's randomness and length
- Separation from family members, friends, and caregivers
- Family atmosphere
- Parental resilience
- Exposure to media coverage
- Economic hardship

Keep in mind that children who have witnessed the disaster only via the media can also experience stress reactions.

Focus on helping children understand the terrorist event, regain a sense of safety, and resume activities. Below are suggestions to help them cope.

- Answer questions about what happened or what could happen honestly and at a level the child will understand, without dwelling on scary details.
- Openly admit to children that you cannot answer all questions.
- Encourage children to express emotions by talking, drawing, or painting.
- Encourage children to express their feelings to adults, including teachers and parents.
- Allow silences.
- Encourage children to participate in recreational activities.
- Help children understand that there are no "bad" emotions.

Also, advise parents, caretakers, and teachers to follow the advice below.

- Stay calm and take care of themselves.
- Do not allow the terrorist event to dominate family or classroom time indefinitely.
- Put together emergency plans and include children in the process.
- Give children lots of love and extra attention.
- Validate children's fears and reassure them verbally, telling them the adults will do everything possible to protect them.
- Watch news coverage with children so the adults can answer questions and give support.
- Limit children's viewing of news coverage, as it can further traumatize children and/or enhance their fears/nightmares. Consider the age and maturity of the child when deciding how much to limit.
- Maintain routine and regular discipline.

One-on-one support from a mental health worker and extensive intervention might be needed for children who show instant signs of trauma or more problematic reactions. Such children may appear disoriented, display atypical behavior, or be in shock. Appropriate immediate responses might be:

- Physical comforting, including snacks and blankets
- Rest

- Repeated assurance of safety
- Honest and age-appropriate answers to questions
- Creative materials so they can draw and play
- Opportunity to talk about their feelings

The table below lists age-specific symptoms and intervention options.

Table 4–2. Children's Reactions to Trauma and Suggestions for Intervention[27]

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1–5	• Clinging to parents or familiar adults • Helplessness and passive behavior • Resumption of bed-wetting or thumb sucking • Fear of the dark • Avoidance of sleeping alone • Increased crying	• Loss of appetite • Stomach aches • Nausea • Sleep problems, nightmares • Speech difficulties	• Anxiety • Generalized fear • Irritability • Angry outbursts • Sadness • Withdrawal	• Give verbal reassurance and physical comfort • Provide comforting bedtime routines • Help with labels for emotions • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Demystify reminders • Encourage expression regarding losses (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

[27] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
6–11	• Decline in school performance • School avoidance • Aggressive behavior at home or school • Hyperactive or silly behavior • Whining, clinging, acting like a younger child • Increased competition with younger siblings for parents' attention • Traumatic play and reenactments	• Change in appetite • Headaches • Stomach aches • Sleep disturbances, nightmares • Somatic complaints	• Fear of feelings • Withdrawal from friends, familiar activities • Reminders trigger fears • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self-blame • Guilt	• Give additional attention and consideration • Relax expectations of performance at home and at school temporarily • Set gentle but firm limits for acting out behavior • Provide structured but undemanding home chores and rehabilitation activities • Encourage verbal and play expression of thoughts and feelings • Listen to child's repeated retelling of traumatic event • Clarify child's distortions and misconceptions • Identify and assist with reminders • Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, and identifying at-risk children

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
12–18	• Decline in academic performance • Rebellion at home or school • Decline in previous responsible behavior • Agitation or decrease in energy level, apathy • Delinquent behavior • Risk-taking behavior • Social withdrawal • Abrupt shifts in relationships	• Appetite changes • Headaches • Gastrointestinal problems • Skin eruptions • Complaints of vague aches and pains • Sleep disorder	• Loss of interest in peer social activities, hobbies, recreation • Sadness or depression • Anxiety and fearfulness about safety • Resistance to authority • Feelings of inadequacy and helplessness • Guilt, self-blame, shame, and self consciousness • Desire for revenge	• Give additional attention and consideration • Relax expectations of performance at home and school temporarily • Encourage discussion of experience of trauma with peers, significant adults • Avoid insistence on discussion of feeling with parents • Address impulse to recklessness • Link behavior and feelings to event • Encourage resumption of social activities, athletics, clubs, etc. • Encourage participation in community activities and school events • Develop support programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens

Older Adults[28]

Older adults may in some ways be uniquely resilient to the grief and trauma of terrorist events. The wisdom and experience accrued over a lifetime can provide tools to help cope with loss, changes, and painful emotions. As older adults become more physically frail or have significant health problems, however, their reactions to terrorist events can be greatly affected by their physical needs. When an older person is already feeling vulnerable due to changes in health, mobility, and cognitive abilities, the feelings of powerlessness and vulnerability associated with a terrorist event can be overwhelming. Sudden evacuations from nursing or residential facilities can be disorienting and confusing. Sensory impairment may cause older adults to be unresponsive to offers of help. Some could reject mental health help because of the fear of being institutionalized, while others might have trouble filling out assistance forms. Below are other ways that older adults could be affected.

- Overwhelming grief after losing grandchildren.
- Fear after losing children who were their primary caretakers.
- Distresses over having to step in to care for a child whose parents have died. This reaction is intensified as they worry about changing their lifestyle and making sure there is enough money to care for an extra person in their household.
- Memories of combat that could be stirred up in war veterans who have seen a disaster site.

Loudoun County Experience With Older Adults

It was interesting to observe older adults after 9/11. With the insight of people who have lived many years, have seen many things, and had personal trials and hardships, they were the first to "move on." The honesty with which they chose to continue with their lives means, ultimately, that to be a survivor it is important to put things in perspective. This population was able to do this very effectively.

My personal story in relation to the Community Resilience Project (CRP) is a little different from those of others on my team. I was already an employee of Loudoun County with the Department of Parks and Recreation with the Area Agency on Aging. Since 9/11, I have had the pleasure of working with many older adults who were already "plugged in" to the system. A person dealing with this population soon realizes how important trust is. I was already "in." I was able to respond to their concerns, and they did not have to be concerned about talking to a "stranger." They knew very well who I was, and we already shared interest in and love for each other.

Services for older adults need to be coordinated with senior groups, caretakers, and health care providers. When assessing the needs of older adults, consider the following:

- Trauma and loss
- Psychological and physical stress
- Medical and health status, including their senses, memory, and mobility

[28] Adapted from DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners, and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- Cultural background, including past trauma and loss
- Availability and proximity of support systems
- Living situation, including assistive features of their homes, such as shower rails and emergency phone numbers on speed-dial
- Priority of concerns and needs

The table below lists symptoms that older adults may exhibit, as well as intervention options for providing services to them.

Table 4–3. Reactions to Trauma and Suggestions for Interventions with Older Adults[29]

Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
• Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems	• Worsening of chronic illnesses • Sleep disorders • Memory problems • Somatic symptoms • More susceptible to hypo- and hyperthermia • Physical and sensory limitations (sight, hearing) interfere with recovery	• Overwhelmed and shutting down • Depression • Despair about losses • Apathy • Confusion, disorientation • Suspicion • Agitation, anger • Fears of institutionalization • Anxiety with unfamiliar surroundings • Embarrassment about receiving "handouts"	• Provide strong and persistent verbal reassurance • Provide orienting information • Ensure that physical needs are addressed (water, food, warmth) • Use multiple assessment methods, as problems may be underreported • Assist with reconnecting with family and support systems • Assist in obtaining medical and financial assistance • Encourage discussion of traumatic experience, losses, and expression of emotions

Rural Communities[30]

Reactions to terrorism and willingness to accept mental health help can also be linked to the surroundings in which we live. The rural culture differs from urban areas in the seasonal effect of the work, in accessibility, and in free time available. Besides the normal phases people experience after a disaster, there are other timing considerations. In a farming area, times of ground preparation, seeding, and harvest typically offer reduced accessibility of outreach workers to the affected population. Consideration should also be given to the differing roles and corresponding

[29] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

[30] Adapted from Jackson, G., Cook, C. (1999). Disaster mental health: Crisis counseling programs for the rural community. (DHHS Publication No. SMA 99-3378). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

stressors that apply to men, women, and children in the area. Switching the focus of service delivery to coincide with stress levels and availability may help the program's efficacy overall.

Some ethnic or cultural groups may not be receptive to services, and gaining their trust may be a challenge. Establishing key community contacts and matching outreach workers to the communities they are trained to serve can create opportunities for service. Sensitivity to language, traditions, and cultural values is vital.

Even if a rural area appears to be homogeneous, ethnic differences can exist. Differences might exist in educational background, religious beliefs, country versus town dwellers, farmers versus ranchers, people who live by the river versus those who do not, etc. Some small communities are as divided by income, education, and religion as are the most diverse inner-city neighborhoods.

I feel that it is a lot harder to get into the rural areas; in many ways it's like a subculture. They tend to take care of their own. They tend to think of themselves as very independent, self-reliant, and very resilient. They often don't want outside help, especially "government" help. So, it was very hard to gain their trust if you didn't have an "in" into that community. Perseverance was the key. We sent people over and over again. We did 4H fairs. We did school activities. We were at the libraries and at the churches, both of which were key in getting into the rural areas.

June Eddinger
Project Director, Loudoun County
Community Resilience Project

A sense of independence and self-determination is a hallmark of the residents in rural areas. Many rural residents tend to view themselves and their communities as possessing a higher quality of life and a more realistic, down-to-earth lifestyle than their urban counterparts. Family, close friendships, and a highly developed sense of community combine to create a sense of self-sufficiency that persists even in the most difficult circumstances. Frequently, in times of disaster, these values are demonstrated as family, friends, and community members provide mutual support, shelter, and care to one another.

Rural people may not actively seek help. Residents of rural areas often are not aware of services available or how to access them. They may think the process is too cumbersome or intrusive. It is also common for a farmer or small business owner not to apply for assistance due to pride, an underestimation of loss, or a belief that others are more in need of help. If the decision is made to apply for assistance, the process may be particularly difficult for someone unaccustomed to admitting need and seeking assistance. Asking for help is very difficult when the cultural expectation is competence and self-reliance.

Receiving any form of mental health services may be seen as a negative reflection on a person's character or family life. This pervasive attitude is even more prevalent in rural communities. Disaster survivors may have a negative impression of mental health services and thus would be offended if made to believe they needed such support. Having fewer mental health resources in a community and a self-reliant cultural bias, people in rural communities may lack an understanding of the need and use for mental health services. Therefore, it is recommended that programming and project identity avoid the use of mental health jargon and frame services in terms of disaster survivors deserving counseling services.

In rural America, traditional organized religion is often a powerful presence. The religious traditions of individuals, families, and communities have become the primary expression of their sense of right and wrong, moral and immoral, good and bad. These traditions provide the structure and language by which the rural population evaluates the world and makes decisions. Such a personal belief system can aid greatly in the disaster recovery process. In rural communities, faith-based communities provide a valuable resource for finding and serving literally hundreds of people. Collectively, the community faith-based centers represent a cross-section of the local social structure with respect to income, education, vocations, and community involvement.

When providing services to rural community members, consider the points below.

- Respect their reluctance to discuss mental health issues.
- Team with appropriate community gatekeepers. Often, these are individuals from families that are respected in the community.
- Approach them from a wellness perspective.
- Use messages of resilience and encourage them to stay positive.
- Take time to earn their trust.

Rural communities that are growing and transitioning to a more urban environment may have some special needs, too. The CRP, for example, found that some residents who were new to communities were in some ways more open to discussing their mental health needs than their more established counterparts, but they were likely to experience vulnerabilities, such as a lack of established support systems and animosity against them by longtime residents.

First Responders

Emergency workers—police, rescue squads, firefighters—are often the first ones on the scene and the last ones out. Long hours, harsh working conditions, and a close-up view of death and destruction leave them vulnerable to intense trauma reactions.

Working with Firefighters and Paramedics

I have worked with several of the firefighters and paramedics who responded to the Pentagon on September 11 and were part of the recovery efforts. In the first stages, I did ride-alongs at four stations to gain trust, educate them about the program, etc. I went on the "Fireline" show for the department in November 2001, and again in November 2002, to discuss the Community Resilience Program and how persons would recognize symptoms of stress.

By December 2001, I had spoken with many of those who responded, and I even had some "dinner-time firehouse discussions." Others would seek me out individually, just to express difficulties sleeping or images coming into their minds. The wife of a paramedic who was part of the recovery met with me several times during the first 6 months because she was having nightmares and was crying when the news came on. Her husband also stayed on my "watch" because, although he is a "tough guy," he was having a stress reaction of increased irritability, and some family problems had come up that made it more challenging.

I have continued occasional ride-alongs and events so that these people remain familiar with me. Often, different fire or paramedic supervisors will contact me saying they have a concern and will ask me to come out to the station.

Specifically, first responders are affected by:[31]

- Scale of an event
- Randomness of an event
- Failure to save people immediately or at all
- Exposure to carnage
- Identifying with survivors
- Direct threat to life or of harm
- Erratic work schedules and environments
- Fatigue
- How clearly they understand their role
- How much training, experience, and equipment they have to do their job
- Authority issues within their organizations
- Jurisdiction issues with other agencies
- Cultural clashes with communities or other workers
- How they are perceived by a community

[31] Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs.

The most severe reactions arise when first responders:

- Are overexposed to the dead and dying
- Deal with corpse removal, especially of children
- Experience extreme fatigue and physical exhaustion
- Are exposed to toxic agents like chemical or radioactive material

Personal situations, such as problems at home or fantasies about being heroes, also shape first responders' experience with terrorism.

In particular, lack of social support could leave some first responders vulnerable. Police officers, for example, often work solo or with one partner. The solitary nature of their business gives them few chances to build supportive relationships—the closest bond they have might be with their partner. Should something happen to their partner, it could be devastating.

Firefighters treat each other more like family. They share meals together and sometimes even live in the same house. Having more people to talk to, however, does not mean they will share their feelings. Like law enforcement workers, many firefighters worry about being labeled "unfit for duty" if they open up about being scared or anxious.

So when do first responders need the help of disaster mental health workers?

Watch for these stress reactions: [32]

- Shock
- Impaired concentration
- Irritability and anger
- Confusion and disbelief
- Distorted perception of situations
- Terror and despair
- Intrusive thoughts
- Guilt
- Decreased self-esteem
- Feeling powerless and helpless
- Grief
- Disassociation with individuals and activities

[32] Ibid.

While these reactions are common, in the long term they could lead to depression, chronic anxiety, or retraumatization. They could also cause or worsen existing problems at work, with families, or with substance abuse.

Stress prevention and management needs to be incorporated into training by employers. If first responders are reluctant to open up in job-sponsored forums, however, they may consider getting help from outside their working world. This could include a community program or mental health services provided by phone or online. They may respond more positively in an environment that recognizes their contributions and respects their silences. It is important that intervention should be individual, voluntary, and at a pace with which first responders are comfortable. The table below offers immediate and longer term suggestions you can give first responders to help manage their workload, maintain a balanced lifestyle, reduce stress, and conduct a self-assessment for trauma reactions.

Table 4–4. Approaches for Stress Prevention and Management for First Responders[33]

Dimension	Immediate Response	Longer Term Response
Management of workload	• Clarifying with immediate on-site supervisor regarding task priority levels and work plan • Recognizing that "not having enough to do" or "waiting" is an expected part of crisis mental health response • Delegating existing "regular" workload so that workers are not attempting disaster response and their usual job	• Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") • Conducting periodic review of program goals and activities to meet stated goals • Conducting periodic review to determine feasibility of program scope with the human resources available
Balanced lifestyle	• Ensuring nutritional eating and hydration; avoiding excessive junk food, caffeine, alcohol, or tobacco • Getting adequate sleep and rest, especially on longer assignments • Engaging in physical exercise and gentle muscle stretching when possible • Maintaining contact and connection with primary social support	• Maintaining family and social connections away from program • Maintaining (or beginning) exercise, recreational activities, hobbies, or spiritual pursuits • Pursuing healthy nutritional habits • Discouraging overinvestment in work

[33] Adapted from DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Dimension	Immediate Response	Longer Term Response
Stress reduction strategies	• Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) • Using time off to "decompress" and "recharge batteries" (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times	• Using cognitive strategies (e.g., constructive self-talk, restructuring distortions) • Exploring relaxation techniques (e.g., yoga, meditation, guided imagery) • Pacing self between low- and high-stress activities, and between providing services alone and with support • Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions
Self-Awareness	• Recognizing and heeding early warning signs for stress reactions • Accepting that one may not be able to self-assess problematic stress reactions • Over-identifying with or feeling overwhelmed by survivors' and families' grief and trauma may result in avoiding discussing painful subjects • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995)	• Exploring motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) • Understanding when "helping" is not being helpful • Understanding differences between professional helping relationships and friendships • Examining personal prejudices and cultural stereotypes • Recognizing discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety, which interferes with the capacity to "be" with clients • Recognizing over-identification with survivors' frustration, anger, anguish, and hopelessness, resulting in loss of perspective and role • Recognizing when own disaster experience or personal history interferes with effectiveness • Being involved in opportunities for self-exploration, and addressing emotions evoked by disaster work

Military

During the 9/11 attack at the Pentagon, the military emerged as a major population that disaster mental health workers targeted for services. These workers had to consider the military's history and culture in dealing with crisis situations, as well as factors that create daily stress for members of the military and their families—such as war, deployments, dangerous field exercises, and constant moves that leave many far from their families and friends. A terrorist event and the resulting heightened security at military installations could increase their stress and anxiety, and lead to the need for intervention.

It is important to know that the military is a close-knit community with a history of responding as an organized unit. Training and working together closely for long periods of time creates a feeling of belonging and cohesion. Disaster mental health workers need to recognize and respect this system, and approach senior command personnel first. Establishing relationships with them and getting their approval early will be especially helpful in gaining access to the military.

In the military, mental health treatment is considered to be under heavy stigma. Whether it's myth or real, many military personnel believe that receiving mental health services can interfere in their career by going on their record, which in turn could potentially interfere with getting top-secret clearance. So it is very important that, when doing disaster work with the military community and the military establishment, we are mindful that it is not traditional mental health. It is not diagnosing people. Rather, it is helping people to understand that the reactions, not the symptoms that they are having, are natural actions to an unnatural situation. You can help them to understand that by encouraging them to participate in information sharing and seminars on stress management. You can get the word out that difficulty with sleeping or concentrating are transient reactions that most people have in this type of situation and, with a little bit of time, the reactions will probably go away.

Ruby E. Brown, Ph.D.
Project Director, Arlington
Community Resilience Project

In addition to setting up general information sessions, senior leaders can provide insight into military life. Consider the points below when planning services for the military.

- Be aware of rank structures and military courtesies.
- Hold separate meetings for senior officers and junior enlisted military members.
- Help senior staff take care of the younger troops by providing services in accordance with the needs and parameters set by the commanding officer. As immediate supervisors, senior staff members provide an invaluable channel for reaching the troops.

It is also important to know how to help if deployments are ordered in the midst of crisis. Following 9/11, soldiers being sent to Afghanistan were more worried about the families they were leaving behind than themselves. Address their fears and let them know their families will be taken care of. Back home, partner with military chaplains and family support groups to provide services for families of deployed units.

It is helpful to start an open dialogue by having an outreach worker who is a former military member lead the disaster mental health team. This may make it easier for soldiers to open up and for disaster mental health workers to penetrate what could be a hard-charging, tough exterior. Being honest about limitations in understanding military culture and making services voluntary and confidential will enable this process.

Consider coordinating efforts with the military community's natural support systems. Military chaplains, for example, are an excellent resource and are often the first people on the scene. Others gatekeepers include:

- Rapid response teams comprising psychologists, psychiatrists, social workers, and chaplains

- Community services and assistance centers
- Family readiness groups
- Ombudsmen
- Spouses of senior enlisted staff
- Spouses of executive officers

Other Considerations

Terrorist disasters affect many different groups in different ways. It is important for the mental health response to assess which groups have been affected and how they have been affected. This section shares provides CRP's experience with other groups and illustrates how disaster mental health workers need to identify and provide appropriate services to each of these groups.

People with physical disabilities may feel extremely helpless if separated from caretakers or special equipment or assistance, such as wheelchairs, hearing aids, walking sticks, or seeing-eye dogs. As much as is possible, the specific physical needs of people with different sight, hearing, and mobility issues need to be met. Outreach materials, for example, can be produced with closed captioning or written in Braille. Also, interpreters can be used to help communicate in sign language.

Reaching the Deaf and Hard of Hearing

The CRP helped members of the deaf and hard of hearing community recover by providing group and individual crisis counseling using deaf and hard of hearing counselors. Ultimately, the goal was to connect service providers and train the trainers to provide psychological preparedness education to the deaf and hard of hearing community. The deaf and hard of hearing counselors also presented a workshop on psychological preparedness at the National Deaf and Hard of Hearing in the Government conference held at the National Institutes of Health. The presentation was standing room only and demonstrated the desire for such information in the deaf and hard of hearing community.

People with mental/emotional disabilities can feel especially terrified and confused when terrorism hits. Not fully understanding what happened can lead to additional trauma, which may require extra medication or hospitalization. When providing services, consider the points below.

- Recognize people may "rise to the occasion" with resilience.
- Tailor services to meet people's specific mental health needs.
- Watch closely for trauma reactions that are similar to symptoms of mental illness.
- Monitor people with PTSD who could react to triggers such as sirens and feelings of powerless that may remind them of past trauma.

Economically disadvantaged communities are underresourced in terms of economic assets. Often, social assets are worn down and strained prior to the event, making it more difficult for residents to draw on traditional social networks during and after an event. Protective factors are weak and in some cases nonexistent. Individuals from underresourced neighborhoods may also have a higher rate of exposure to trauma as a result of neighborhood violence, family dysfunction, and alcohol and substance abuse.

With the great diversity in our county—1 out of 5 people are not born in the United States—there's not only a great number of different ethnicities and races involved, but there's also a great deal of variation in terms of how long people have been here, how acculturated they are, and how they have acclimated to the American society's demands on them. Most of the recent immigrant populations are at a very early stage in terms of their economic development, and some of them were economically devastated by the economic downturn following the 9/11 attacks. There was a very disproportionate amount of negative effects on people who were very isolated, very fearful, very scared of the government as well as the terrorists. This exacerbated our difficulties with accessibility to the people who needed our services most.

Bill Scarpetti, Ph.D.
Clinical Director, Fairfax
Community Resilience Project

In areas with strong social networks before a terrorist attack, the goal after an attack is to help sustain and support those networks to assist individuals and the community in their recovery. In areas where the social supports are weaker, a terrorist attack could further weaken those supports. The goal in this case is to identify members of the community who may be impacted by the further reduction of support to help them recover.

Before 9/11, taxi drivers might not have been an obvious group of people who could be affected by terrorism. But after the attacks and the downward spiral of the tourism industry, many taxi drivers found themselves out of work—and out of money. The stress of being unemployed only added to the anxieties of experiencing a terrorist event.

As families in Northern Virginia curbed travel and shopping in favor of the comfort and care of their homes, their decreased spending also led to lost jobs and high stress for:

- Displaced airport workers
- Small business owners
- Service industry workers
- Tourism industry workers

9/11 truly devastated everyone in the community in some way or another, and the different ways that it affected people really did surprise me. For example, how personally the airline industry took it, and how hard it was for them to think "Why didn't I catch the person?" "Why didn't I do this?"

June Eddinger
Project Director, Loudoun County
Community Resilience Project

Some data indicate that women may be more susceptible to the effects of terrorist events. Research following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City found that, compared with men, 6 months after the bombing, women had twice the rate of PTSD and more than twice the rates of depression and generalized anxiety disorder. Women are more likely to be single parents and caregivers for older adults or disabled family members. They also tend to be emotional caregivers for their immediate families.

Summary

To provide effective mental health services to different groups, disaster mental health workers are encouraged to assess their level of cultural awareness and seek to increase it by gaining an understanding of how these differences influence reactions to tragic events. Community gatekeepers and leaders are an invaluable resource during this process, as they provide information about vulnerabilities, access, communication, and other issues.

Understanding and appreciating different populations is not only about what is in a community profile or what gatekeepers have to say—it requires a continual assessment of the salient population groups that require assistance as a result of terrorist events, and looking at how they and their situations change. Be patient, be flexible—and be watchful. There will always be new groups to help and new ways to help them.

Additional Resources

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Fed Stats, http://www.fedstats.gov.

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National Association for Rural Mental Health, http://www.narmh.org.

National Center for Cultural Competence
Georgetown University Center for Child and Human Development
3307 M Street, N.W., Suite 401
Washington, DC 20007-3935
Toll free: 800-788-2066
Tel: 202-687-5387
Fax: 202-687-8899
http://www.gucdc.georgetown.edu/nccc/

Office of Minority Health Resource Center
U.S. Department of Health and Human Services
P.O. Box 37337
Washington, DC 20013-7337
Toll free: 800-444-6472
Fax: 301-251-2160
http://www.omhrc.gov

U.S. Census Bureau, http://www.census.gov/population/www/index.html.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. Menlo Park, CA: National Center for Post-Traumatic Stress Disorder, U.S. Department of Veterans Affairs, http://www.ncptsd.org/publications/disaster/index.html.